Gender and Economic Policy Discussion Forum

Maternal Health and Maternity Entitlements in India

FORUM XIX | 05 MAY 2016 BRIEFING NOTE 19

HIGHLIGHTS / KEY POINTS

- Maternity entitlements irrespective of all sectors need to be unconditional and universal by not being linked to the age of the woman or the number of children.
- Maternal health and family planning have been viewed exclusively as a women's domain. It is important to locate men's responsibilities within a gender equality framework that addresses maternity, paternity and care as collective responsibilities.
- Moreover, maternity entitlement needs to be approached as a family entitlement that is focused not entirely on women, but also children.
- Data driven planning around socially excluded health communities and how they get health care calls for qualitative research to understand the lived realities of these people and devise interventions built upon the way they live their lives.
- Maternal health and maternity entitlements need to be safeguarded in accordance with the principles of equal opportunities and treatment in occupations and employment instead of forced measures that impinge on women's liberties.
- Cash cannot substitute for services. Basic social guarantees that constitute national social protection should provide access to essential maternal health and income security.

The issue of maternal health, in a country experiencing high maternal mortality and child mortality, is a major policy concern. Safe maternity practices and health care for infant survival and the mother lies at the center of life itself. It is also vital to the productivity of women, and to ensuring gender equality and guaranteeing decent work at the workplace. Entitlements for mothers need to assure "that the woman can maintain herself and her child in proper conditions of health and with a suitable standard of living" (ILO, 2014). However, multiple yet intersecting aspects define maternal health and entitlements in different contexts and settings, such as wage compensation, women's own sense of security and well being, child rights, child health, nutrition and food security[1].

The Gender and Economic Policy (GEP) Discussion Forum on 'Maternal Health and Maternity Entitlements in India' held on 5th May 2016 discussed how maternal health and maternal entitlements have translated to different sectors in India, and the outcomes of development schemes thereof. It concluded with recommendations on policy design and implementation geared towards fortifying gender equality that encourages maternity protection and work-family policies by safeguarding maternal and child health. The speakers at the forum were Sejal Dand from ANANDI, Dipa Sinha from Ambedkar University, Abhijit Das from the Centre for Health and Social Justice and Subhalakshmi Nandi from UN

Women. The discussion was chaired by Vandana Prasad from Public Health Resource Network.

Maternal Health in India: Social Exclusion and Beyond

The health of women and children has been a matter of global concern for the last few decades[2]. The World Health Organization defines maternal health as "the health of women during pregnancy, childbirth, and the postpartum period". Improper health care facilities before, during and after child birth could lead to maternal morbidity and mortality. "WHO estimates show that out of the 536,000 maternal deaths globally each year, 136,000 (25.7%) happen in India"[3]. Although in the recent years, the Maternal Mortality Ratio in India has dropped to 178 in 2010-12 from 212 deaths per 100,000 live births in 2007-09, India is yet to achieve the target of 103 deaths per live births set by the United Nations-mandated Millennium Development Goals (MDGs) by 2015[4]. India's rapid stride in bringing maternal mortality down in the last ten years is seen as a poster case in many global arenas[5]. Abhijit Das argues that this reduction in maternal mortality is mostly attributed to the policy change toward institutionalized deliveries in the last few years. Despite the recent moves to push all women into having institutional deliveries and greater use of public facilities for delivery, reduction in maternal mortality where maternal mortality is worst does not seem to be taking place. He underlines how low coverage of services in general, non-streamlined referral services in particular, lack of universal availability of comprehensive emergency services and high levels of unsupervised home deliveries lead to overall poor quality of care during institutional deliveries.

Studies testify to the unequal access that poorest rural women with least literacy and women from certain states in northern and central India have to antenatal care and childbirths in hospital compared to women from the higher wealth quintile who are educated[6]. The emphasis for such inequitable access to health care is usually on issues of poverty and wealth. But what should be taken into consideration is the issue of social exclusion. Women who are born into the socially excluded communities such as the scheduled castes, or are tribal-India's indigenous groups- such as those residing in the central, eastern and northern regions of the country, experience a deeper level of exclusion from quality health care[7]. What is worse, is that not only is there no reliable data on maternal health status of socially excluded communities available since the National Family Health Survey 3 (2005 – 06), and the District Level Household and Facility Survey 2008, the Annual Health Survey series did not provide caste disaggregated data[8].

Likewise, domestic workers also do not have any access to a uniformly applicable and comprehensive national legislation that ensures decent conditions of work and fair terms of employment[9]. What is also lacking is active participation on the part of the state that recognizes the existing structural inequalities and the 'sheer weight of care work' (UN). Finally surrogacy as an act and as an industry remains contentious since reproductive labour could be interpreted either as work or as labour of love. In the context of the Madras high court bonding leave case, Subhalakshmi Nandi elaborated on the changing family configurations that define surrogate parents today. The Madras High Court delivered a landmark judgment for mothers who opted for children through surrogacy by holding that such government employees would also be entitled to 'maternity leave' in the form of 'child care leave'. The object of such a leave was to take care of the child and develop proper bonding between the child and the parents (Subramani, 2013).

As Subhalakshmi Nandi argues, maternal health needs to be viewed in the light of the enabling environment that the child needs. This for her forms

the backbone of most legal cases that are fought in the best interests of the child. It can only be achieved by promoting equal sharing of family responsibilities between parents, and by involving fathers with their infants and young children that will also have positive effects on child development (ILO, 2014). Research shows that fathers, who take two weeks or more leaves immediately after childbirth are more likely to be involved with their children (ILO, 2014). This will also help in shifting relationships away from prevailing stereotypes, and alter parenting roles towards more gender equal relations in the home and at work (ILO, 2014). In the Indian organized sector similar levels of discrimination against pregnant women at work prevails, albeit on a different landscape and setting.

Maternity Entitlements in India: Reflections on Some Developmental Schemes

In India, concerns regarding maternal and child health care could be traced back to the First (1951-56) and Second (1956-61) Five Year Plans. The government-initiated Minimum Needs Programme that was introduced in the Fifth Five Year Plan (1974-79) integrated maternal and child health services with family planning with the objective of providing basic health care services and nutrition to pregnant women, lactating mothers and preschool children. These supportive measures, among others, collectively termed as maternity entitlements or maternity benefits, not only finds mention in the Constitution's Directive Principle of the State Policy but "were governed mainly by the Maternity Benefit Act, 1961 (MBA) and a few other sectoral/labour laws".[10]

The Maternity Benefit Act, 1961 seeks "to regulate the employment of women in certain establishment for certain period before and after child-birth and to provide for maternity benefit and certain other benefits"[11]. The maximum period for which entitlements are provided to women, however, vary between the central and state establishments spanning different sectors. The central government employees get full-day protection for two years up to the child is 18 months while state government employees get 12-24 weeks, depending on the state's discretion[12]. While the Ministry of Human Resource Development has recently issued guidelines of 32 weeks for PhD students enrolled in universities, within the Act itself, contractual, plantation, factories and establishments and all other salaries, get 12 weeks- and this is yet to be revised[13]. What is worse is that despite a major percentage of the total female workforce being employed in the unorganized sector, the government has failed to formulate and implement any schemes[14].

Some programmes supported by the central and state governments reflect the distressing quality of services that fail to complement obstetrics care for expecting women. The National Rural Health Mission (NHRM) was launched in the year 2005 to provide health security to women, children and the poor residing in the rural areas. Adopting a synergistic approach that covered central determinants of health like sanitation, hygiene, nutrition and safe drinking water, its major goal was to reduce infant and maternal mortality rate, and prevent communicable and non-communicable diseases. The Janani Suraksha Yojana (JSY) was another programme under the NHRM that was launched the same year to encourage safe motherhood interventions by reducing maternal and neo- natal mortality and promoting institutional delivery among poor pregnant women.

Although these programmes contributed to reducing the infant mortality rate from 58 in 2005 to 50 in 2009 and increasing institutional deliveries from 10.84 million in 2005-06 to 16.21 million in 2009-10[15], nonetheless, only a low proportion of the

targeted population could benefit through the schemes launched under the NHRM such as the Chiranjeevi Yojana, and other central and state schemes such as the Dr. Muthulakshmi Reddy Maternity Benefit Scheme, Janani Suraksha Yojana (JSY), Conditional Maternity Benefit (CMB), Indira Gandhi Matritva Sahyog Yojana (IGMSY), Prasuti Araike, Madilu Yojana, and Mamta (Vora et. al., 2014). Moreover, programmes such as the JSY have not only low coverage of services but follow a conditional cash transfer policy based on women's income status, age and number of children[16]. Further, these schemes are linked to conditions such as institutional delivery and provide meagre amounts as benefit[17].

Dipa Sinha upholds the National Food Security Act, 2013 (NFSA) as a landmark legislation that recognized how all women work and deserve to be supported during pregnancy and childbirth. She quotes section 4 of the NFSA that states how in accordance with the schemes of the Central Government "every pregnant woman and lactating mother shall be entitled to… Maternity benefit of not less than rupees six thousand," except those employed by "Central Government or State Governments or Public Sector Undertakings or those who are in receipt of similar benefits under any law"[18]. Nevertheless, the IGMSY that was launched in 2010, and brought under the NFSA, 2013 could cover only 28 per cent of the targeted beneficiaries[19]. Likewise most beneficiaries were misinformed or unaware about the scheme with delays in registering pregnancies and opening bank accounts because of which delayed payment was a trend across states and no sampled beneficiary received the first instalment of IGMSY cash during pregnancy[20]. Similarly, current schemes for maternity entitlements were linked to several conditionalities which include registering within the first trimester, getting Iron/ Folic Acid tablets, immunising the child, attending growth monitoring and self-certifying that she has exclusively breastfed the child for 6 months[21]. As a result women with three or more children or women younger than 19 years were excluded from this scheme, despite the fact that it was between the ages of 14 to 19, that a very large number of pregnancies took place. Dipa Sinha underlined how the exclusion of women as a result of the two selection criteria of age (over 19 years) and available only for two deliveries/children, amounted to 56 per cent in Bihar, 44 per cent in Madhya Pradesh, 49 per cent in Jharkhand and 40 per cent in Chhattisgarh. Also, no growth monitoring sessions were organized as required every month. Worse, with entitlements linked to residence, migrant women could not meet such conditions and avail of the maternity benefits[22]. Likewise women who delayed in registering pregnancy within the first four months had similar experiences[23]. Such issues related to design, implementation and funds need to be taken into consideration while designing future policies and amending the existing ones.

Looking Back to Look Ahead: Implications for Policy Change

- **Conceptualizing entitlements to be unconditional and universal:** Programme design is an important requirement for policy implications. It remains as critical as the execution of any programme in order to ensure that desired goals are met. There is an urgent need for central schemes on maternity entitlements to extend their outreach to the 200 high priority districts in India, to begin with. Maternity entitlements irrespective of all sectors also need to be unconditional and universal. They should not be limiting in scope by being linked to the age of the woman or the number of children and other such criteria. Provisions for services such as supplementary nutrition that includes locally prepared foods

and hot cooked meals need to be made available to all pregnant and lactating women at all anganwadi centres. The universal guarantee of at least Rs. 6000 needs to be consequently rationalised as wage compensation. Moreover the revised Maternity Benefits Act (1961) should identify women's work in all spheres and markets without discrimination, and for all purposes of care, reproduction, and subsistence. It also needs to extend guarantees of maternity entitlements to all pregnant women, surrogate mothers and adoptive parent(s).

- **Engaging men and families:** Maternal health and family planning have been viewed exclusively as a women's domain. Given that social structures are rapidly breaking in India giving way to nuclear families, it becomes important to locate men's responsibilities within a gender equality framework that addresses maternity, paternity and care as collective responsibilities. Moreover, with the changing family configurations, maternity entitlement needs to be approached as a family entitlement that is focused not entirely on women, but also children. As underscored by Subhalakshmi Nandi, maternal health needs to be viewed in the light of the enabling environment that the child needs.

- **Unpaid work, care and time burdens:** Pregnancy should be look upon as work and rest needs to be provided to expecting women. According to Sejal Dand women largely carry the burden of domestic work in the global south that include a lot of time and energy in providing water for domestic use, collecting fodder, cooking as well as 'care' work. However maternity benefits, she emphasize, have translated into conditional cash transfer schemes, not recognizing the fact that reproduction is work. Likewise, Vandana Prasad underscores that there has to be a universality of the principle that a woman needs this support. At the same time we need to do away with the hegemony of policy making while agreeing to a universality of requirements. She also reasons that since basic requirements remain universal, it is the interpretation of these that need to be contextualized. Intersectional ties incrementally enhance vulnerabilities that make it essential to track vulnerabilities with their intersectionalities.

- **Addressing the socially excluded:** With a conscious move into data driven planning Abhijit Das argues, information around socially excluded health communities and how they get health care has been missing for the last ten years. Evidence based policy making is not in the interest of people who were in the margins of the bell curve. Such a discourse would be completely alien to the reality of the marginalized people. Abhijit Das maintains how maternal mortality could be routinely preventable with good nutrition, emergency obstetric care, antenatal care, skilled attendance at delivery, and family planning. He also stresses the need for qualitative research to understand the lived realities of these people and devise interventions built upon the way they live their lives. He argues how these must include both traditional home based and life saving interventions by integrating traditional home care and emergency obstetric care services. He further underlines the need to train health care workers appropriately at the field level and the facility level, while ensuring minimum wage and nutrition support to women for fifteen months of pregnancy and six months of infant care. He also suggests that proper design and monitoring of programmes could be done through a specially constituted committee comprising leaders from socially

excluded communities, public health experts and medical experts.

- **The politics of policymaking and the inadequacy of services:** With the big chasm that remains between care indicators vs. social indicators, Vandana Prasad argues how cash does not substitute for services. Basic social guarantees that constitute national social protection floors should provide access to essential maternal health and income security (ILO, 2014). Besides as agreed by all speakers, coercive measures such as making child sex determination during pregnancy compulsory, and registering the gender of the child while tracking the birth will just curtail civil liberties by enhancing government overreach (Khan, 2016). Maternal health and maternity entitlements need to be safeguarded in accordance with the principles of equal opportunities and treatment in occupations and employment (ILO, 2014) instead of forced measures that only impinge on women's liberties.

- **Strengthening social protection:** Unpaid care work and maternity need to be made key components of social protection programmes. Social care services in particular need increased public investment and maintenance as these act as social stabilizers by creating jobs in the care sector and promoting women's opportunities to engage in quality work (ILO, 2014). At the same time, it is important to ensure that employers are not afraid of hiring professional women. This can be achieved by mandating that employers contribute to a tripartite welfare fund in organizations irrespective of the fact that they employ a pregnant woman or not. Employers can be prevented from bearing the cost of societal well being and reproduction by engaging in 'risk pooling' through public funds or social insurance for social care services and leave benefits that will promote non-discrimination at work (ILO, 2014).

Gender equality at home and at work can only be consolidated through quality and affordable gender-sensitive cash transfers, social care services, and employment guarantee schemes that in the long run help in reducing inequality and poverty (ILO, 2014). Finally, maternal health needs to be viewed in the light of the enabling environment that the child needs and should be fortified before, during and after the child's entry into the family.

Endnotes

[1] Vandana Prasad at GEP Discussion Forum XIX, 5th May 2016

[2] United Nations Global Strategy for Women's and Children's Healths, United Nations, Office of the Secretary General, New York, NY (2010)

[3] IIM Ahmedabad Report, 2008

[4] http://www.livemint.com/Politics/3uK62sim31WSgbyB5Bw4AP/Indias-maternal-mortality-rate-falls-but-still-a-long-way.html

[5] Abhijit Das at GEP Discussion Forum XIX, 5th May 2016

[6] (Caldwell 1986; Dyson and Moore 1983; McCarthy and Maine 1992; Mosley and Chen 1984; Basu 1992; Bhatia and Cleland 1995b; Bloom et. al. 2001; Dasgupta 2011)

[7] Abhijit Das at GEP Discussion Forum XIX, 5th May 2016

[8] Abhijit Das at GEP Discussion Forum XIX, 5th May 2016

[9] Sejal Dand at GEP Discussion Forum XIX, 5th May 2016

[10] Dipa Sinha at GEP Discussion Forum XIX, 5th May 2016

[11] www.ilo.org/dyn/travail/docs/678/maternitybenefitsact1961.pdf

[12] Sejal Dand at GEP Discussion Forum XIX, 5th May 2016
[13] Sejal Dand at GEP Discussion Forum XIX, 5th May 2016
[14] Sinha et. al., 2016
[15] Pillai, 2011
[16] Abhijit Das at GEP Discussion Forum XIX, 5th May 2016
[17] Sinha et. al., 2016
[18] The Gazette of India Extraordinary, 2013
[19] Falcao and Khanuja, 2015
[20] Dipa Sinha at GEP Discussion Forum XIX, 5th May 2016
[21] Dipa Sinha and Sejal Dand at GEP Discussion Forum XIX, 5th May 2016
[22] Sejal Dand at GEP Discussion Forum XIX, 5th May 2016
[23] Dipa Sinha at GEP Discussion Forum XIX, 5th May 2016

Bibliography

Basu, A.M. (1992). Culture, the Status of Women and Demographic Behaviour. Oxford: Clarendon.

Bhatia, J.C. and Cleland, J. (1995). Self-Reported Symptoms of Gynecological Morbidity and Their Treatment in South India. *Studies in Family Planning* 26:203-16.

Bloom, S.S., Wypij, D., and Gupta, M.D. (2001). Dimensions of Women's Autonomy and the Influence on Maternal Health Care Utilization in a North Indian City. *Demography*. 38:1.

Caldwell, J.C. (1986). Routes to Low Mortality in Poor Countries. *Population and Development Review* 12:171-220.

Dyson, T. and Moore, M. (1983). On Kinship Structure, Female Autonomy and Demographic Behavior in India. *Population and Development Review* 9:35-60.

Falcao, V.L., and Khanuja, J. (2015, March 28). India's Unrealised Maternity Entitlement. *The Hindu*.

Feminists India. (2016, March 8). *Maternity entitlements must be universal and unconditional*. Retrieved from http://feministsindia.com/maternity-entitlements-must-be-universal-and-unconditional/

Khan, H. (2016, February 2). Make Sex Determination Must, Then Track Mothers: Union Minister Maneka Gandhi. *The Indian Express*.

McCarthy, J. and Maine, D. (1992). A Framework for Analyzing the Determinants of Maternal Mortality. *Studies in Family Planning* 23:23-33.

Mehta, N. (2013). India's Maternal Mortality Rate Falls, But Still a Long Way To Go. Retrieved from http://www.livemint.com/Politics/3uK62sim31WSgbyB5Bw4AP/Indias-maternal-mortality-rate-falls-but-still-a-long-way.html.

Mosley, W.H. and Chen, L.C. (1984). An Analytical Framework for the Study of Child Survival in Developing Countries. *25-45 in Child Survival: Strategies for Research*, edited by W.H. Mosley and L.C. Chen. New York: Population Council.

Pillai, S. (2011). The "Social Protection Floor" in India. Retrieved from www.icsw.org/doc/2011- Social-Protection-Floor-in-India.doc

Sinha, D., Khanuja, J., Nehra, S., Matharu, S. and Falcao, V.L. (2015). Indira Gandhi Matritva Sahyog Yojana: Challenges and Recommendations for Improvement. *Centre for Equity Studies, New Delhi*.

Sinha, D., Khanuja, J., Nehra, S., Matharu, S. and Falcao, V.L. (2016). Realizing Universal Maternity Entitlements: Lessons from Indira Gandhi Matritva Sahyog Yojana. *Economic and Political Weekly 51(34), New Delhi*.

Subramani, A. (2013, March 6). Mother of surrogate child entitled to maternity leave: Madras High court. *The Times of India*.

The Gazette of India Extraordinary. (2013). The National Food Security Act, 2013. Retrieved from http://indiacode.nic.in/acts-in-pdf/202013.pdf.

United Nations Global Strategy for Women's and Children's Healths, United Nations, Office of the Secretary General, New York, NY (2010).

Vora, K.S., Yasoband, S. and Mavalankar, D.V. (2014). Predictors of Availing Maternal Health Schemes: A community based study in Gujarat, India. *Indian Journal of Community Health*, 26:2, 204.

Vora, K.S., Mavalankar, D.V., Ramani, K.V., Upadhyaya, M. and Sharma, B., (2008). Maternal Health Situation in India: A Case Study. *Indian Institute of Management, Ahmedabad, India*.

Speakers at the Forum

Chair:

Vandana Prasad: Vandana Prasad is a community pediatrician and public health professional who is Joint Convenor of Jan Swasthya Abhiyan (Peoples' Health Movement-India), member of the Steering Committee of Right to Food Campaign and National Convenor of Public Health Resource Network.

Panelists:

Sejal Dand: Sejal Dand is a feminist activist who currently holds positions as founder director ANANDI and advisor to the commissioners of the Supreme Court in the Right to Food case. Her current engagements are with institutionalising women's livelihood rights and social protections in campaigns, policies, programs and NGO's.

Dipa Sinha: Dipa Sinha is Assistant Professor, Economics at Ambedkar University, Delhi. She is actively involved with the Right to Food Campaign and Working Group for Children under Six (of the Right to Food Campaign and Jan Swasthya Abhiyan).

Subhalakshmi Nandi: Subhalakshmi Nandi is a development professional, working on diverse issues of gender equality, and women's rights and empowerment, with a focus on mainstreaming gender concerns in development and in livelihoods policies and programs. She currently leads the women's economic rights portfolio at the UN Women Office for India, Bhutan, Maldives and Sri Lanka (based in New Delhi). She has played a leadership role in national campaigns and networks such as Collective on Women's Unpaid Work, MAKAAM (Forum for Rights of Women Farmers), Self Help Groups and Equity; and the Citizens' Collective against Sexual Assault.

Abhijit Das: Abhijit Das is the Director of the Centre for Health and Social Justice, in India and Clinical Assistant Professor at the Department of Global Health at the University of Washington, Seattle. He is currently the Co-Chair of MenEngage, a global alliance of NGOs working with men and boys on gender equality, and Convenor of COPASAH a global health rights and social accountability network.

Gender and Economic Policy Discussion Forum

presented by

ISST
INSTITUTE OF SOCIAL STUDIES TRUST
Core 6 A, UG Floor, India Habitat Centre, Lodhi Road, New Delhi - 110003
Phone: +91-11-4768 2222 Website: www.isst-india.org

in association with

HEINRICH BÖLL STIFTUNG INDIA
C-20, Qutab Institutional Area, New Delhi - 110 016
Phone: +91 11 26854405, 26516695 Website: http://in.boell.org

Kaagaz International, 98112 30592